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PHILADELPHIA, JUNE 9, 1877.

ORIGINAL LECTURES.

ASPIRATION IN COMPLICATED CASES OF PLEURAL EFFUSION.

BY WILLIAM PEPPER, M.D.,

Professor of Clinical Medicine in the University of Pennsylvania.

Reported by SAMUEL M. MILLER, M.D.

II.—PNEUMO-PYOTHORAX DUE TO CATARRHAL PNEUMONIA FOLLOWING TYPHOID FEVER.

IN connection with the case which was the subject of the lecture published in the last number of this journal, the following case was exhibited.

Case II.—J. L., 21, admitted to Philadelphia Hospital on October 29, 1876. His previous general health has been good. He was admitted to the medical wards of the hospital in the second week of an attack of typhoid fever of moderate severity. The case presented the characteristic eruption and course of febrile action. There were mental hebetude and slight wandering, but no severe nervous symptoms. There was moderate diarrhœa. The bronchial symptoms were but slightly marked, and physical examination showed merely symptoms of congestion of the posterior parts of the lungs. Towards the end of the second and third weeks the temperature ranged between $100\frac{1}{2}^{\circ}$ and $101\frac{1}{2}^{\circ}$ in the mornings, and $102\frac{1}{4}^{\circ}$ and $103\frac{1}{4}^{\circ}$ in the evenings, which latter was the highest point reached. The patient was treated with tonic doses of quinia, moderate stimulation, nitrate of silver, and opium, fluid diet, frequent spongings, and absolute rest in bed. Towards the close of the third week the symptoms rapidly subsided, and on the morning of November 11, about the twenty-fourth day of the disease, the temperature had fallen to $97\frac{3}{5}^{\circ}$. A slight rise occurred on the following day, but on the morning of November 13 it was again noted at 97° , and in the evening at 99° . The following day, without any distinct chill, there was an abrupt rise of temperature to $104\frac{4}{5}^{\circ}$ in the evening; this was not sustained, but for several days ensuing there was a daily variation in temperature of wide range; simultaneously with this there also appeared great acceleration of the pulse and very rapid respiration. The patient complained of a sharp pain on the right side, and, on examination, friction-sound was heard extensively over the right chest. In addition to this there was feeble respiration over the right lung and over the upper lobe of the left lung, with scattered subcrepitan râles. The strength failed rapidly, and the pulse and breathing

continued very frequent. The temperature for several days fell to 97° or 98° in the mornings, though in the evenings it rose nearly to 103° . Subsequently, after November 20, the morning temperature no longer fell below the normal until November 23, when it again fell to 97° , with a sudden development of intense dyspnœa. Physical examination showed distention with almost entire immobility of the right chest; marked tympanitic percussion-resonance, absence of the respiratory sounds, occasional metallic tinkling, and succussion-splash. After this sudden development of pneumothorax the patient did not rally. The respirations were very hurried and shallow, and the face cyanosed. All nourishment was refused, and the temperature slowly rose to 101° on November 29, and death followed on November 30.

At the post-mortem examination there were scattered points of catarrhal pneumonia found already passing into the cheesy stage in the upper lobe of the left lung. On the right side there was extensive exudation of lymph on the pleura, the lung being in places coated with layers of recent lymph nearly one inch thick. Posteriorly there was a collection of $\frac{1}{2}$ viij of pus included between the layers of lymph. There were also $\frac{1}{2}$ xxiv of light, straw-colored fluid lying free in this pleural cavity, and in addition to this there was very extensive pneumothorax, the amount of air being great enough to distend widely the pleural sac, and to compress the right lung until its tissue was carnified. It was impossible to detect the point at which the air had escaped into the pleural cavity, the large amount of lymph formed having already covered the orifice, which was undoubtedly minute. A section of this lung showed numerous points of catarrhal pneumonia, some in the stage of cheesy degeneration, others with the formation of small pus-containing cavities. There was still some ulceration of the glands of Peyer near the ileo-cæcal valve, and at several points there was cheesy degeneration of the swollen gland-tissue. The mesenteric glands were also enlarged.

Remarks.—The well-developed character of the symptoms of the original attack leaves no room for doubt that it was one of typhoid fever, and this was confirmed by the post-mortem appearances. There was no exposure of any kind to account for the attack of pleuro-pneumonia, and it must be probably regarded as septic in its nature and connected with the absorption of the resulting cheesy degeneration of the products of the typhoid exudations of the bowels. It was developed in the fourth week; but the changes in the Peyer's patches were somewhat retarded, owing to

the absence of proper elimination. It is very important to recognize the absorption of these morbid products in the later stage of typhoid fever as a source of constitutional infection with the development of miliary tubercles or of septic processes in the lungs. The symptoms which mark the existence of pneumothorax were very prominent. It is interesting to note the occurrence of the abrupt fall of temperature and the development of partial collapse in immediate connection with this accident. The physical signs were so clear as to leave no doubt as to its nature. It was attributed, as in the former case, to perforation of the pulmonary pleura from the softening of a sub-pleural tubercle, or focus of catarrhal pneumonia. There is little doubt that such was the real mode of access of the air to the pleural sac, though at the autopsy inflation of the lung failed to detect the point of perforation. This was, however, easily accounted for by the abundant formation of lymph on the pleural surface. Numerous points of softening immediately beneath the pleura were actually found. The intensity of the pulmonary pleural lesions is remarkable, considering their short duration,—only sixteen days; but careful examinations of the chest during the early days of the attack left no doubt as to the exact date of their development. The explanation of their rapid progress and fatal tendency is doubtless to be found in the state of the system at the close of the long-continued fever, and in the septic origin of the lung-disease. These influences must always be borne in mind and have due weight attached to them in framing the prognosis in pneumonias consecutive to typhoid fever. The peculiar course of the temperature subsequent to the development of lung-trouble, with its morning fall of 97° or 98° , was strongly suggestive of the existence of centres of suppuration either in the lung or pleura, such as were actually found. The treatment adopted on the development of the pneumonia was a considerable increase in the amount of stimulus, large doses of quinia and carbonate of ammonia. It is needless to add that although the existence of some pleural effusion was clearly recognized, and although on the occurrence of pneumothorax the effects of mechanical disturbance of respiration were very threatening, it was impossible to entertain the idea of operative interference.

ORIGINAL COMMUNICATIONS.

CASES ILLUSTRATING THE DIFFICULTIES IN DIAGNOSIS AND TREATMENT OF ANEURISMS OF THE LOWER EXTREMITY.

BY JOHN B. ROBERTS, M.D.

INTERNAL aneurisms are proverbially difficult of accurate diagnosis, and their treatment is likewise fraught with uncertainty and risk. Similar lesions of the extremities, it would seem, ought to present much more characteristic symptoms and be in a greater degree amenable to medical and surgical treatment. The numerous mistakes that have been reported by experienced observers, however, show that this is not the case, for, notwithstanding the comparatively superficial position of the arterial trunks in the extremities, aneurismal dilatations are very serious lesions for the surgeon to attack. In the *American Journal of the Medical Sciences* for 1874, Dr. Stephen Smith has given us an account of a large number of cases where it was impossible to make an absolute diagnosis for or against aneurism until the question was solved by the result of treatment, or by the investigation of the pathologist after death. Again, Dr. Erskine Mason, in the same journal for January, 1877, reports a case in which he ligated the femoral artery for a case of supposed popliteal aneurism, but which was subsequently determined to be a sarcomatous growth. In the *Philadelphia Medical Times* for March 21, 1874, I recorded an instance of spontaneous aneurism of one of the branches of the dorsalis pedis artery, where there was great doubt as to whether the tumor was aneurismal or a ganglion receiving impulse from the subjacent artery. Professor Gross, at whose clinic the patient applied, cut down upon the small tumor to establish its nature, and, finding it to be an aneurism as suspected, enlarged the wound and ligated the anterior tibial near the ankle. Secondary hemorrhage supervened, and the artery was tied a second time higher up; but the patient died some days later, apparently from pyæmia.

Several somewhat similar cases have occurred recently in the wards of the Pennsylvania Hospital, which are of interest on account of the obscurity of diagnosis and the various methods of treatment adopted.

The first case was that of a large popliteal tumor, occurring in a negro aged 26 years, which presented few of the characteristics of aneurism, and yet, from the result of treatment, must be considered as such. The patient four years previous to admission had observed a swelling in the right ham after having, he says, received a strain. He had no marked trouble until about two months since, when he found the tumor increasing; and three weeks ago this compelled him to resign work. There was no history of syphilis. On admission the right knee was semi-flexed, and the popliteal space was occupied by a large mass extending more to the inner side of the limb; the length of the tumor was seven inches, and the girth of the limb over the patella about nineteen inches. There was no pulsation and no thrill in the tumor, which was the seat of pain, and auscultation over the inner side revealed no murmur. The ear at this examination was unfortunately not applied to the outside of the mass. The tibial arteries could not be felt at the ankle. Over the heart there was heard a systolic murmur, probably the result of an old attack of rheumatism which he had had six years previously. The diagnosis lay between aneurism, deep abscess, and some heterologous growth, and in order to clear up the case an aspirating trocar was inserted into the tumor.

A stream of blood, which rapidly coagulated, flowed from the tube, but not in jets; there was no pus mixed with the blood, and pressure on the femoral did not immediately check the flow, though compression continued for some time did seem to do so. The inguinal glands were enlarged, and the saphenous vein was somewhat distended. The day after the tumor was thus tapped, auscultation revealed a distinct, harsh, systolic murmur, heard especially over the outer aspect of the tumor, though it was also perceptible on the inner side of the leg. When the superficial femoral artery was compressed for some time, the swelling in the ham became much less tense and diminished in size. This was further tested by applying the Esmarch bandage and cutting off the circulation for five minutes, when the tumor became very much softer and the girth decreased one-half inch. An attempt to determine the difference in temperature of the feet was not very satisfactory.

It was plain that there was a hemorrhagic tumor in the popliteal space, for the result of the tapping was conclusive on that point. The needle had either entered the cavity of an aneurism or been inserted into a hemorrhagic cancerous growth. Which was the true condition was hard to determine; without the aspirator needle even this much would not have been decided, for the murmur could have readily been caused by pressure from any solid growth compressing the popliteal artery. The question of treatment had to be mooted, and was equally un-

satisfactory. If the growth were cancerous, early amputation was the safest course; if aneurism of the sacculated variety, ligation or compression was indicated; but if it were a dissecting aneurism, amputation might be required primarily, or secondarily after some less heroic procedure had been attempted. At the consultation the propriety of controlling the circulation and making an incision down to the tumor was discussed, which would give more certain data; for if the trouble were aneurismal, suppuration of the sac requiring free incision was not unlikely to occur whatever operative procedure were undertaken, and should the swelling be cancerous the wound would not be contra-indicated.

Finally, Dr. R. J. Levis, under whose care the patient was, decided to ligate the femoral artery in Scarpa's triangle and await results, as this was a more conservative procedure than amputation. This was accordingly done with a carbolyzed catgut ligature, and the wound closed. The murmur of course immediately ceased, but no marked diminution in the size of the tumor occurred. The swelling, however, became very soft and fluctuating, so that it was confidently thought that suppuration within the sac of the supposed aneurism had taken place; and it was decided to withdraw some of the fluid with the aspirator. By accident this was postponed and the tumor never punctured. Very gradually the tumor then began to diminish, and the patient, who had been in good condition and had had little or no pain in the knee after the ligation, regained the use of the limb, and was discharged two months after the operation with only slight swelling remaining.

The second case was in the ward of Dr. William Hunt, and was very different from the first, in that the diagnosis was easily made and the result unexpected.

A man, aged 40 years, whose occupation compelled him to climb awning-posts a great deal, had received years ago a gunshot wound of the inner side of the right leg, near the middle, where a small cicatrix could be seen. His friends say he had a partially-stiff knee for years, though he seems to think that he felt no pain until a week before admission, and he only relinquished work three days ago. On account of the patient being absolutely deaf, it is difficult to obtain an accurate history of the disease.

Examination showed a tumor, the size of a small orange, situated posterior to the head of the right tibia, which was the seat of an expansive pulsation, a distinct thrill, and a loud systolic murmur. Compression of the femoral at the groin caused these signs to disappear. The girth of the left leg at the same point was eleven and a half inches, while that of the right was thirteen and a quarter; when the circulation was cut off by pressure, the meas-

urement fell to twelve and a quarter inches. No cardiac murmur was detected, and there was no history of syphilis. The radial artery did not appear atheromatous, and the dorsal artery of the foot was thought to be pulsating.

This, then, was a typical case of aneurism, and seemed to be a sacculated one, connected with the lower portion of the popliteal or one of the tibial arteries. Treatment by compression was deemed eminently adapted, as forced flexion exerted no influence, because the aneurism was below the joint and opposite the head of the tibia. This method was preferred to ligation, partly because of the success attending a case of external iliac aneurism treated by complete compression by Dr. Levis in the hospital in 1871. In this instance, according to Dr. Levis's report, published in the *Philadelphia Medical Times* about a year later, the patient was kept etherized for five hours and a half, during which time the vessel was completely controlled by the pad of a compressor placed three and a half inches above Poupart's ligament. In the case before us, then, Dr. Hunt determined to try compression, and the pad, placed near the apex of Scarpa's triangle, was retained in position for twelve hours. During the first five or six hours the current was almost if not entirely arrested, because at times no pulsation whatever could be perceived in the tumor, though occasionally it was feebly felt. During the last half of the time, however, pulsation was marked, but I, who had the immediate supervision of the treatment, was afraid to increase the pressure lest gangrene should supervene, and determined to maintain partial occlusion for the rest of the time. Partial flexion of the knee was also employed, and the patient kept well narcotized. Subsequently the pulsation seemed diminished, but, owing to the inflammation of the skin caused by the instrument, no further pressure was applied. Forced flexion was continued without any change taking place. Twenty days later, the compressor was again applied to the femoral, and the man enjoined to keep it screwed up as much as he could bear, but to relax the pressure occasionally when the pain could not be endured. This was the treatment for two days, when it was found that the thrill had disappeared and that the pulsation was so feeble that at times it could be no longer certainly felt. The bruit remained. The tourniquet was used for a day or two longer in the same manner, but omitted at night. Consolidation was evidently taking place, and everything looked propitious; but soon a cloud appeared on the surgical horizon. On the fifth day after the patient began to use the compressor to produce partial arrest of the arterial current, swelling of the leg and great pain in the ham occurred. All compression was discontinued, and the limb enveloped in anodyne lotions. About the same condition of things lasted for four weeks: the swelling decreased a little and

the pain gradually diminished, while the tumor was the seat of such feeble pulsation that it is impossible to state whether any actually existed. There seemed every reason to suppose that suppuration was about to occur in the aneurism, which had become filled with clot; but fluctuation did not present itself. At the end of this period, blebs appeared on the surface of the leg, and there were developed rather sudden symptoms of incipient gangrene, beginning in the neighborhood of the ankle. Further conservation was useless and delay hazardous, and accordingly, after consultation, amputation of the thigh was done six inches above the knee-joint. Dr. Longstreth, the pathologist of the hospital, found the posterior tibial region filled with over a quart of laminated and soft black clot, which had pushed aside and forced itself into and around the muscles. No structure could be identified as a vessel or aneurismal sac. The popliteal artery, as far as the middle of the space, appeared normal, and then passed into the mass of clots. The head of the tibia and the bone just below were somewhat roughened, and a portion of the periosteum was removed. No bullet was found imbedded in the tissues, and at the time of dissection the parts presented no evidences of suppuration.

This was evidently an ordinary sacculated aneurism, which at some period of the treatment ruptured and became diffused. The symptoms of the trouble were so characteristic and decisive when first examined, that it seems certain that the aneurism was not diffused at that time; but after partial consolidation of the tumor had occurred, the weakened walls gave way and allowed extravasation among the muscular structures of the calf. This probably took place at the time when the limb rather suddenly became swollen and painful, during the use by the patient himself of partial compression. A case very similar to this was reported at a recent meeting of the New York Pathological Society, where a diffuse aneurism of the anterior tibial artery was followed by gangrene, necessitating amputation, and in which the first diagnosis in the case was cellulitis of the leg. In the present instance, it is impossible to say why the sac ruptured after partial consolidation of the aneurismal contents and a diminution of the blood-current had been effected by pressure upon the femoral; and yet it would appear that such was the fact. The patient, after the amputation of the thigh, did well, and was discharged cured.

A third case of aneurism was admitted by Dr. Levis on March 12, 1877.

The patient, aged 58, while at work, nine or ten months previously, observed a swelling in the right groin, which always pulsated, and which increased gradually until it was as large as an orange. According to Dr. Hand's notes, the man gave no specific history, and said that the trouble was noticed after a hard day's work. The aneurism extended from one inch above Poupart's ligament down to the apex of Scarpa's triangle, and from the pubic symphysis outward to the ilio-pubic eminence. Pulsation could be felt when the fingers of the examiner were seven and a half inches apart. The dilatation therefore involved the iliac and femoral arteries just as the vessel passes from the abdominal cavity upon the thigh. In order to avoid, if possible, the ligation of the external iliac artery, it was determined to introduce a quantity of clean horsehair into the sac to favor deposition of fibrin and the consolidation of the aneurism. This method of treating aneurism was adopted in a case of thoracic aneurism by Dr. Levis some years ago, and would possibly have been successful if the tumor had not been of the diffused variety instead of sacculated, as was supposed. A long, delicate trocar was thrust into this ilio-femoral aneurism, and four long pieces of horsehair introduced through it. The trocar was then withdrawn, in order to leave the hair curled up in the sac. Unfortunately, however, two pieces, being entangled in the trocar, were dragged out with it, leaving within two pieces which measured each about sixteen and a half inches. In the course of three or four days the pulsation seemed slightly diminished, as though there was beginning fibrinous deposit, but at the same time inflammation of the overlying skin, tending towards sphacelation, occurred, and the sloughing threatened to open the sac. The patient stated that a somewhat similar attack of cutaneous inflammation had occurred once before. The danger of rupture of the sac from sloughing and fatal hemorrhage was so great that it was determined to wait no longer for the horsehair to induce coagulation, but to ligate the external iliac artery. Accordingly, four days after the introduction of the hair, an incision was made, from the crest of the ilium to within an inch of the pubic symphysis and half an inch above the crural arch, and a carbolized gut ligature applied. The patient showed symptoms of peritonitis afterwards, and died on the eleventh day subsequent to ligation. No autopsy was obtained, but the sac was opened, and the hairs and a mass of soft black clot found therein.

These three cases are worthy of study as showing the variety of phases that may be assumed by apparently simple and uncomplicated cases of aneurism. In the second case, cure seemed almost accomplished, but the rupture of the sac necessitated amputation by inducing gangrene; the third case

unexpectedly required ligation on the cardiac side of the tumor, on account of sloughing of the superficial structures; while patient number one, when amputation was deemed almost the only chance of recovery, was cured by a simple ligation, without any bad symptoms.

INTERSTITIAL NEPHRITIS, IN WHICH THERE WERE MARKED RETINAL CHANGES, PERICARDITIS, AND PERICARDIAL EFFUSION.

BY JAMES H. HUTCHINSON, M.D.

Read before the Pathological Society of Philadelphia, Feb. 22, 1877.

I SHOULD hardly have thought it worth while to bring these specimens before the Society, as they illustrate a very common form of kidney-disease, were it not for the fact that the ophthalmoscope enabled me to make a correct diagnosis in the case some days before I became acquainted with any fact in the patient's history throwing any light upon the nature of the disease from which he was suffering. The patient, who spoke nothing but Italian, a language I do not understand, presented, when first admitted to the Pennsylvania Hospital, the appearance of a man convalescent from typhoid fever. An examination of the urine revealed the fact that it contained both casts and albumen, but it would scarcely have been possible to say what particular form of Bright's disease was present, had not a careful examination of his eyes with the ophthalmoscope been made. There was nothing in his case to call particular attention to his eyes, and no doubt the marked retinal changes which were present would have been overlooked except that it is now my rule to use the ophthalmoscope in every case of albuminuria coming under my care at the hospital.

Before the patient had been many days in the ward, several attacks of epistaxis had occurred. These were so profuse that after the failure of ordinary styptic injections the nostrils were plugged both anteriorly and posteriorly. This tendency to epistaxis, indeed, was for some time the only unfavorable feature of his case, but its frequent occurrence, together with the retinal hemorrhages, gave me but little hope that there would be even a temporary improvement in his condition. The presence of a

moderate amount of hypertrophy of the heart is not without interest, as it is to this condition that the retinal hemorrhages have been ascribed by some authorities. It was also present in the only other case of retinal hemorrhage accompanying Bright's disease in which I have had the opportunity of making a post-mortem examination. In both these cases pericarditis was set up towards the close of life, and in both, doubtless, was the proximate cause of death. In the case which forms the subject of this communication it was of very slight grade, and, although the præcordial region was frequently examined, escaped detection; nothing more than a very soft murmur, evidently of anæmic origin, being ever heard. This was probably due to the effusion present, which, although small in amount, was sufficient to keep the two surfaces of the pericardium apart.

The following history was obtained through an interpreter some days after the patient's admission:

B. B., æt. 25, single, sailor, Italian, admitted February 1, 1877; died February 13, 1877. Until the beginning of his present illness he does not remember ever having been sick, with the exception of an attack of gonorrhœa eight or nine years ago. He appears to have been formerly addicted to the use of alcohol in excess, but since he came to this country, two years ago, he has been temperate. For the last year he has had frequent and profuse hemorrhages from the nose, and for eight months has been obliged to rise at night to pass his water. He has only considered himself seriously ill for the past two and a half months. Ten days before admission he noticed slight œdema of the legs, but has never had headache or dimness of vision.

Upon admission the patient is well nourished, but is mentally rather dull. Upon a close examination the legs and eyelids are found to be slightly œdematous. His tongue has a brownish coating at the base and at the sides, and is slightly fissured, so as to suggest the possibility of his having recently passed through an attack of typhoid fever, which view of his case is confirmed by the frequent occurrence of attacks of epistaxis, and by the presence of tympany and of sudamina.

Auscultation of the lungs reveals a few subcrepitant râles at base of chest, especially upon left side. A soft murmur is

heard over the body of the heart which is conveyed feebly both to base and to apex.

The urine is clear, pale, acid; specific gravity, 1010; no sugar; contains albumen one-fourth, and very large granular casts which seem to be free from fat.

February 4.—An ophthalmoscopic examination reveals a healthy disk with central excavation, the vessels being quite small. Striated appearance of retina, upon which were found, especially in the neighborhood of disk, numerous white patches, and hemorrhages both recent and old. About a quart of urine is passed in twenty-four hours.

In spite of iron in the form of the tincture of the chloride, and of the fluid extract of ergot, and of styptic injections, the bleeding from the nose continued, and it was necessary as a last resort to plug the nostrils. The patient, however, removed the plugs, whereupon the hemorrhage recurred, under which he sank early on the morning of February 13. An examination made shortly before death showed that patient's urine contained, in addition to the casts before seen, numerous white and red blood-corpuscles.

The temperature of patient while in the hospital never exceeded 99°, and was frequently as low as 97°.

Autopsy, by Dr. Morris Longstreth, thirty-two hours after death.—Rigor mortis marked; general surface of body pale; no fluid in subcutaneous connective tissue; no emaciation; small quantity of clear serum in abdomen; no evidences of inflammation. Serum and adhesions in both pleural cavities, especially marked at apices posteriorly. Pericardium contains sufficient serum to separate the two layers; serum cloudy, and contains flocculent lymph. Lymph is also adherent generally over surface of heart. Left heart firmly contracted, right heart relaxed. Right ventricle contains fluid blood, watery in character; right auricle contains a fibrinous clot. Left ventricle empty, its walls in contact; left auricle contains a small chicken-fat clot. Weight, sixteen ounces. Valves normal. Left ventricle hypertrophied.

Lungs.—Right, very œdematous, exudes abundant frothy serum, slightly bloody. At right apex a puckering of the lung-tissue; beneath it a white nodule, size of a pea; on section shows a cheesy consistence in centre, surrounded by fibrous envelope.

Upper part of lower lobe on section is deeply red, consistence lessened, surface of section not granular.

Left lung—congestion more marked; on section, serum the same in amount as on the other side, but more bloody; no softening; cut surface not granular. At left apex there is a similar nodule as at right; its centre, however, is not cheesy.

Spleen.—Weight, six ounces. Small, firm, adherent on outer surface; capsule thickened. On section, brownish-red. Presents a normal appearance.

Kidneys.—Left. Weight, three and a half ounces. Small, regular in outline. On section, tissues very pale, large vessels prominent and presenting open calibres. Cortex very much reduced, is streaked, opaquely white; capsule thickened, tightly adherent, though it does not tear the tissue on removal. Surface of the kidney finely granular.

Right kidney. Weight, three and a half ounces. Cortex more reduced than that of left, and the tissue of organ is firmer, otherwise it presents very much the same appearances. Both kidneys have a urinous odor. Perinephritic connective tissue very cedematous.

Liver.—Weight, three pounds and six ounces. Adherent to diaphragm by bands of firm connective tissue. Outline irregular; color normal; tissue very firm.

Skull.—Calvaria normal; dura mater very pale; no subarachnoid effusion; vessels of pia mater only partially filled with blood. Nothing abnormal found in any part of the brain.

Eyes.—Both retinae showed evidences of old and recent hemorrhages, more markedly in the right than in the left.

CASE OF UNUSUAL FŒTAL POSITION.

BY J. CHESTON MORRIS, M.D.

AT 9 A.M., April 13, 1877, I was summoned to attend Mrs. P., aged 26 years, in her third labor. Her condition during each pregnancy has demanded constant care and attention, as she suffered greatly from nausea, deranged urinary and alvine discharges, threatened miscarriage after very slight exertions, and occasional œdema of the face and extremities. She has also choreic twitchings of the muscles of the face even when in ordinary health.

At my visit I found a slight bloody discharge from the vagina, pains occurring regularly, cervix nearly effaced, os tincæ somewhat rigid but yielding so as to allow the passage of one finger. The pains did not seem so effective as they should have been from their severity. I therefore administered gr. vj of sulphate of quinia; gr. iij more to be taken every two hours. I saw her again repeatedly during the day; the os slowly dilated, but the pains seemed effectual only when maintained by the presence of one or more fingers in the os. At 11 P.M. things remained much in the same state; the os was now dilated to one and a half inches, and the membranes protruded. Thinking the process of dilatation might now be left to nature, aided by the eighteen grains of quinine she had taken, she was left for the night. But at 6 A.M. of the 14th the os was found irregular and soft, membranes not protruding, pains recurring regularly, but without accompanying muscular contraction. As her general condition was good, she was left without active interference until 2 P.M., when six grains more of quinine were administered, and dilatation of the os with the finger again attempted more successfully, as by 4.30 P.M. the circle was two inches in diameter, and membranes protruding. As she had suffered from hydramnios in her last labor, I thought best now to rupture the membranes. When the waters had drained away, which they did but slowly, I endeavored to ascertain the position; this was difficult to do, as the mouth of the uterus had receded high up in the pelvis, and the cervical canal was somewhat narrowed. I waited until 9 P.M., when I determined to etherize the patient and terminate the labor. On introducing my hand I found the right thigh and arm and the left ear and posterior part of the head presenting. With considerable difficulty, owing to the resistance of the os internum, I succeeded, after bringing down the right leg, with the toes up, in finding and bringing down the left leg, then the right hand, and finally the left hand; the body of the child rotating during the extraction so as to bring the spine to the pubes. With the assistance of my friend Dr. H. Lenox Hodge, I then applied the forceps to the head, which was tightly grasped in the cervical portion of the uterus, and delivered her of a small male child, which was with difficulty resuscitated; it was feeble, and breathed or rather sighed feebly for nearly a day after its birth; but with care, and five drops of brandy in a little milk and warm water every two hours, it gradually grew stronger, and is now doing well.

The placenta followed immediately on the delivery of the child; there was slight hemorrhage, checked promptly by the use of ergot and a bandage. On the third day Mrs. P. had a slight rigor, followed by a little fever with frequent feeble pulse; but the administration of inf. cinch. comp., alternating every

two hours with milk punch, was followed with good results; she is now doing well.

The malposition of the fœtus was due, I believe, to the attachment of the placenta on the left of the uterus near the junction of the lower and middle segment. I did not use Barnes's dilators, as in one or two instances after their employment I have found a head-position changed unfavorably. Had I done so in this case, I might have accused myself—needlessly, as the event proved—of having caused the subsequent difficulty.

1514 SPRUCE STREET, PHILADELPHIA, April 24, 1877.

NOTES OF HOSPITAL PRACTICE.

COLLEGE OF PHYSICIANS AND SURGEONS, NEW YORK.

CLINIC OF PROF. A. JACOBI FOR DISEASES OF CHILDREN, MARCH 21, 1877.

Reported by P. B. PORTER, M.D.

VALVULAR DISEASE OF THE HEART, WITH HYPERTROPHY.

THIS child (a little girl of six years) was before you some little time ago, and I now find her condition considerably improved. If you will remember, there was quite a marked systolic mitral murmur in her case. In adults, as you are aware, when a mitral murmur once exists it remains forever. In children, on the other hand, these murmurs not infrequently entirely disappear in the course of time. This is explained by the compensation which may result from changes in the shape of the heart and its ostia. The organ becomes hypertrophied, and there is a new adaptation of the valves to the orifices. You will notice the enlarged veins about the neck and breast in this child. Such a condition is abnormal, and shows us at once that there is venous obstruction somewhere. As we have seen, it is in the heart in the present instance. I would also call your attention to the peculiar formation of this chest. It is what is known as the "pigeon breast," and, instead of being elliptical in shape, as it ought to be, it is triangular, with a flat dorsum and flat sides anteriorly. This condition is due to the existence of rachitis in early life, and thoraces of this character sometimes give the idea that hypertrophy of the heart is present when this is in reality not the case; because a larger portion of the organ impedes against such a flattened chest-wall than if the latter were of the normal rounded character.

Here, however, there is no doubt about the existence of actual hypertrophy. In mapping out the outlines of the heart, I find that the percussion-dulness extends a whole inch to the right of the sternum. There is, therefore, an immense enlargement of its right side, and there is in addition a little tipping of the organ to the right. This hypertrophy proves conclusively that the murmur which we hear is not due merely to functional trouble. This little patient has been taking iron, with a little digitalis, and, as she has improved very much under the treatment, we will continue the same.

CHOREA MINOR, WITH VALVULAR DISEASE OF THE HEART.

Here is another child (a boy of eight years) in whom we find the same murmur and the same condition of the heart, except that the enlargement is not so marked as in the last case. You have seen this patient also before; and when he was then presented to you the choreic manifestations were very much more prominent than they are now. It is probable that the same rheumatic trouble which gave rise to the chorea also occasioned the heart affection; and you all know the connection between chorea and disease of the heart. In this case there may or may not have been an endocarditis. This boy has been taking iron and arsenic. We commenced with three drops of Fowler's solution three times a day, and gradually increased the dose to eight drops. In giving arsenic you have to feel your way up carefully, so as to avoid unpleasant symptoms, and you will find a great difference in individuals in their tolerance of this agent. As you have noticed, the patient is very much improved; and we will not therefore push the dose any further than eight drops at present.

SPINA BIFIDA.

The baby now before you (five months old) you will, no doubt, remember also. It was here about two months ago, when I showed you the tumor, filled with fluid, which is situated on the lower part of the spine, and is two inches in diameter and elevated fully an inch above the surface of the back. At that time I told you of the dangers to which the treatment by injection, recommended by some, may give rise, viz., draining of the cerebro-spinal fluid, and meningitis. We found that the tumor had not grown much, but that the head was increasing in size, the anterior fonta-

nelle being remarkably large. Pressure over the fontanelle at that time occasioned convulsive symptoms, and since then, the mother informs us, the child has had a number of spasms,—though none within the last two weeks. You will now notice that upon the upper portion of the tumor there is a bluish portion, indicating a thinning of its walls, which are composed simply of dura mater in this part. In accordance with my directions, the mother has prepared a cup-shaped covering, which is held in position by a band passing around the abdomen, to protect the mass; but there is daily increasing danger of rupture of the sac, which would cause a draining of the brain and spinal canal, and give rise to hyperæmia, meningitis, convulsions, and death. This now seems imminent, and this is, unfortunately, the only prognosis which I can make in the case. My intention was, had the mother consented, to have placed the infant in some hospital, where a small daily puncture could have been made, allowing the escape of two or three drops of the cerebro-spinal fluid, and also where slight but continuous compression could have been kept up. Had this been done, we might perhaps have looked for an entire cure, but only in the course of several years.

On placing my hand over the anterior fontanelle, I am not able to detect any pulsation, or, at all events, it is exceedingly slight; and this indicates effusion undoubtedly. Ordinarily, as long as the fontanelle remains open, the pulse can be felt more strongly there than over the radial or temporal arteries, or in any other part of the body. The complete connection between the brain and the spina bifida is shown when I place one hand on the latter and the other on the anterior fontanelle. When pressure is made upon the tumor I feel a distinct bulging of the fontanelle under my hand, and as soon as the pressure is removed it immediately subsides again. This procedure seems to occasion the infant no uneasiness whatever.

SCOLIOSIS WITH DISEASE OF THE STERNUM.

This child, which is now nearly two years old, was first presented at the clinic eleven months ago. The history then given was that of a pleuro-pneumonia of the right side, which resulted, on account of the contraction of the pulmonary tissues, in a permanent flattening of the chest-walls

and a marked distortion of the spinal column. When I suspend the child by placing my hands in his axillæ, you can plainly perceive that the scoliosis is not functional. Anteriorly, you notice, we have the "pigeon-breast" again, and over the sternum, at its most projecting point, there is an ulceration which has made its appearance since the case was here before. On inserting a probe into the fistulous orifice which here exists, I find that it enters for two-thirds of an inch, and still I feel bone. This means that the bone is much swollen, and osteitis is going on. This process is quite rare in the flat bones, but is of frequent occurrence in the long ones, particularly the phalanges. The old name of *spina ventosa* describes very well the tumefaction that takes place in the bone-substance. In order to prevent spreading of the osteitis and perforation of the bone interiorly in this case, I would inject the cavity with a solution of one or two grains of carbolic acid to the fluidounce of water, and keep the orifice open; and the child ought really to be placed in a hospital, so that it could be treated to the best advantage. It may be that the posterior layer of the sternum is already perforated; but I have not been able to detect this if it is so, for then the probe would have passed directly into the cavity of the thorax.

Now, however, on twisting a pledget of lint into the opening, I find that it is immediately pushed out again by the expansive force of inspiration, which shows that there is no longer a blind cavity, but that perforation has already taken place, leaving the pleura and pericardium in a measure exposed. There is, therefore, so much the more reason to make the injections of which I spoke, and to keep the orifice open, in order to prevent the formation of a peri-pleuritic abscess. It may perhaps be necessary also to dilate the opening. In similar cases in adults I have sometimes found it advisable to make excisions of portions of the ribs.

STRUMOUS OSTEITIS.

This child, now about twenty-one months old, had a fall ten months ago, and from this resulted disease of the zygoma, which has continued up to the present time. It has also been followed by other bone-trouble. About six weeks ago it appeared in the carpal and metacarpal bones on the

opposite side of the body, and within the last four days the lower epiphyses of the humerus, on the same side, have become affected. Now the question arises, is all this osteitis due to the common origin of the fall ten months ago, or are we to attribute it to a general constitutional predisposition to this form of disease? Unquestionably the history of these successive attacks shows a dyscrasia in the system, and the fact that three have occurred within a year leads us to expect that others will follow, unless the condition of the child's constitution can be changed. In young children physiological changes take place more rapidly in the bones than in any part of the system except the brain; and especially are they active in the tissue between the epiphyses and diaphyses. So, too, as we might expect, it is found that pathological changes are exceedingly rapid here. You have seen how frequent disease of the hip-joint is. The epiphysis of the femur in young children is two or three inches long; so that when coxitis occurs in early life, a large quantity of tissue is at once involved, and the whole joint rapidly fills with pus. At the end of the sixth or seventh year, when ossification has progressed very extensively, the disease is not so dangerous, and suppuration does not take place until its third stage has been reached.

In children in whom there is a tendency to dilatation of the blood-vessels, a rapid proliferation of tissue-cells, and the formation of pus (a condition known by many as scrofulosis), the skin, the bones, or the glandular system are affected in different individuals according to the peculiar circumstances of the case. In cases such as this there is sometimes complete recession of the joint, as it is called, within a very few weeks; that is, the suppurative action is so great that the entire epiphysis actually drops off.

Now, here is a child in whom a pathological process is going on in different parts of the osseous system at the same time; and in all probability a number of other epiphyses will still be attacked. But if we could change the character of the tissues there would be no new development of disease; and it therefore behooves us to inquire if there is anything which will so improve the general condition as to fortify the system against further attacks. Well, we might give nitrogenous food, phosphate

of lime, the hypophosphites, cod-liver oil, and syrup of the iodide of iron. The efficacy of phosphate of lime has been much doubted of late, because almost immediately after its administration it is found in the urine. Still, we know that iron does good; and yet about all that is taken seems to pass off in the excreta. The manner in which I have been treating these cases of late is different; but I have been quite pleased with its success thus far. A year ago I commenced giving phosphorus in substance, for the reason that I had read that it had been unquestionably demonstrated that in rabbits fractures of the bones united much more rapidly when phosphorus was administered to the animal than when the process was left simply to nature. In the present case I wish to cause an increase of osseous elements, if possible, and with that intent I shall direct from one-ninetieth to one-sixtieth of a grain of phosphorus to be given to the child three times a day. It may be administered in cod-liver oil if you please.

In the way of local treatment, the opening in the zygoma should be probed from time to time, and a pledget of lint inserted, so as to keep it free for the exit of small pieces of bone which may still come away. A number of such have already done so. The diseased elbow should be protected by a sling, and the hand at present treated with applications of ice.

TRANSLATIONS.

ON THE ENTRANCE OF AIR INTO THE VEINS (*Le Mouvement Médical*, No. 8, p. 121).—M. Louis Couty has made a number of experiments in the laboratory of M. Vulpian to determine the effect of the entrance of air into the veins, and has come to the following conclusions:

Death does not take place through the brain, as the air does not pass beyond the vertebral arteries. It does not paralyze the right side of the heart, the movements of which it excites both mechanically and chemically. Cessation of the heart's action does not occur, except as one of the last phenomena, after paralysis of the voluntary and respiratory muscles. The arrest of circulation was not due to any obstruction of the pulmonary capillaries; the main branches of the pulmonary artery contained pure blood unmixed with air:

no absolute stoppage, but only a diminution of the aortic current, was found to occur.

Having disposed of these theories, M. Couty claims to have established an exact symptomatology which can be practically applied in cases of this accident. He recognizes four points:

1. Diminution of the aortic contents; loss of arterial tension; acceleration of the heart; no general symptoms.

2. More considerable loss of tension; accelerated respiration; syncope; paleness; dilatation of pupils, etc.

3. Aortic current little or nothing; excitation of the motor centres; convulsive movements of the voluntary muscles; involuntary defecation and micturition; respiration slow, deep, apoplectic.

4. No arterial tension; death of the brain and cessation of convulsions; then arrest of respiration; and, finally, stoppage of the heart's action.

The arrest of the pulmonary circulation he believes to be due to a mechanical disturbance of the heart. The gas, sooner or later arriving at the right side of the heart, passes the valves, enters the ventricle, and remains there, dilating by its elasticity the ventricular walls.

This distention may take place slowly, but it is constant, often doubling or tripling the normal size of the right heart. From this distention result the following consecutive phenomena:

1. The contractile force remaining the same, and the resistance augmenting, the auriculo-ventricular contraction becomes more and more incomplete.

2. The walls contracting on a gas instead of a liquid compress it without driving it out.

3. The orifices of the right side remaining patulous, the foaming mixture of blood and air regurgitates into the veins and is carried to the most distant parts of the system. This reverse current persists until the distention passes certain limits, when death results.

After a consideration of the many therapeutic means recommended in this condition, the writer selects two,—one mechanical, the other chemical. The first consists in free venesection, which by diminishing severe pressure diminishes the distention of the heart; the other, in inhalations of oxygen, which by relieving the lungs of the accumulated carbonic acid

facilitate the passage of the air accumulated in the heart.—J. W. W.

APOPLEXY OF THE RETINA IN PERNICIOUS ANÆMIA.—Dr. A. Nykamp, of Leyden (*Berlin. Klin. Wochens.*, Feb. 26, 1877) has made some observations confirmatory in some respects of those by Schiess and Manz, but also to a certain degree contradictory of the results of these observers. Schiess and Manz found the hemorrhagic patches dark brown with a sharply-defined light centre, the latter containing small roundish cells usually with small nuclei, occasionally filled with finely-granular protoplasm. Around these centres were red blood-corpuscles, giving color to the patch. The capillaries showed lateral or ampullar enlargements, empty or filled with white or red blood-corpuscles or with a finely-granular substance almost structureless. These enlargements are either in the calibre of the capillary vessels themselves or in the lymph-sheaths. Schiess and Manz regard the retinal apoplexy as analogous to capillary cerebral apoplexy.

Nykamp observed the brown hemorrhagic patches, but found no white centres. He found the enlargement alluded to, together with the contents observed by Schiess and Manz, but rarely. Red blood-corpuscles were found here and there in the angles between two branching capillaries and in the sheaths of the vessels. Collections of red corpuscles could be observed here and there surrounded by a sort of sheath, and, when of some duration, lighter in the centre but showing the cell-contours distinctly. Nykamp asserts that these last collections are quite independent of the vascular walls. He concludes that the retinal apoplexy does not depend upon rupture of the vessels, but upon diapedesis. Neither the light centres nor the capillary ectases are necessary attributes of these hemorrhages.

X.
POISONING BY THE IRRESPIRABLE GASES DEVELOPED FROM THE EXPLOSION OF DYNAMITE.—Dr. Senft (*Berliner Klin. Wochens.*, 1877, p. 118) gives an account of certain miners poisoned by entering a tunnel just after an explosion of dynamite. The symptoms were those of intense asphyxia. Face and hands dark bluish red; bloody froth at the mouth; ecchymoses of the conjunctiva bulbi; pupils dilated and not reacting to light; entire unconsciousness; pulse small, 125 to 130; skin cool. The respiration was irregular and

shallow, inspiration sometimes stertorous, with puffing of the cheeks during expiration. Auscultation showed signs of pulmonary œdema; weak heart-sound, with occasional diastolic murmur like that heard on compression of the veins of the neck with a stethoscope. Stools, urine, and semen passed. Cold applications to the head, large sinapisms to the chest and calves. Twelve ounces of blood taken, and artificial respiration maintained. The patients could not swallow medicines. No improvement resulting, hypodermic injections of acetic ether were employed, with very favorable results. The patients all recovered, but had severe bronchitis and pharyngitis. The gases developed by the explosion of dynamite are carbonic acid and nitrogen. x.

TRANSFUSION OF BLOOD IN CASES OF PYÆMIA.—This operation has been performed in pyæmia three times by Marcacci (*Annali Universali di Medicina (Parte Rivista)*), December, 1876, p. 504; from *Rivista Scientifica*).—In the first two cases the transfusion was fruitless, but in the third instance was followed by prompt cure. The unsuccessful cases were patients who had had successive chills and in whom the metastatic abscesses had already formed; wherefore the operation of transfusion could not overcome or modify the grave organic alterations. The third one was transfused immediately after the first chill, and a cure resulted.

Human venous blood was first employed, but in the last two instances lamb's arterial blood was the fluid injected. The symptoms after the operative procedure was employed were, it is stated, identical in all the subjects, and consisted of great oppression of breathing, cough, dyspnoea, and agitation; afterwards there followed redness and burning of the face, pulsation of the temporal arteries, full pulse, a feeling of comfort, calm respiration, etc. Sometimes a feeling of hunger was aroused and intelligence became clear, and sometimes profuse sweating occurred. The conclusion derived from the cases is that transfusion can be employed with great advantage in the first manifestations of pyæmia by arresting the morbid processes, but if abscesses have formed, although amelioration may be obtained, a cure is impossible. J. B. R.

TOXIC PROPERTIES OF WATERY INFUSION OF PHOSPHORUS.—Fischer (*Centralbl. f.*

Med., 1877, p. 32) remarks that the question as to whether a watery infusion of matches can give rise to symptoms of phosphorus-poisoning is one of importance from a forensic stand-point. His experiments go to show that such infusions possess markedly poisonous properties. A watery infusion of matches, even after repeated filtration through thick linen, contains so much phosphorus in a finely-divided condition as to be decidedly luminous. The fluid is, however, perfectly transparent, and even after long standing throws down a very few globules of phosphorus. x.

TREATMENT OF CATARRH OF THE BLADDER.—Edlefsen (*Deutsches Archiv f. Klin. Med.*, Bd. xix. Heft. 1) recommends the use of chlorate of potassium in acute as well as chronic vesical catarrh. It rapidly diminishes the proportion of pus in the urine, lessens or even removes the subjective troubles, and keeps the urine acid.

Edlefsen recommends this remedy in these cases more particularly when oil of turpentine, usually a very efficient remedy, is contra-indicated: thus, in co-existing catarrh of the stomach, gastric ulcer, or nephritis, he prescribes ol. terebinth. rectific., in doses of ten drops three or four times a day in capsules. The chlorate of potassium he prescribes in solution,—fifteen to three hundred parts water; a tablespoonful in water every two or three hours. x.

OXIDE OF ZINC IN CHRONIC DIARRHŒA.—Dr. Bonamy (*Bull. Gén. de Thérap.*, 1877, p. 259) has employed this agent with great success in obstinate diarrhœa characterized by the frequent passage of abundant sero-bilious stools, without tenesmus or colic, and with only moderate pain in the abdomen. To prevent nausea and vomiting, he combines the zinc with carbonate of sodium:

R Zinci oxidi, gr. c.;

Sodii bicarb., gr. xvj.—M.

Div. in chart. no. vi. One to be taken every three hours.

In M. Bonamy's experience, even the most rebellious diarrhœas, which had resisted all other means of treatment, yielded to this, and its effect was very rapid. x.

TO PREVENT THE FORMATION OF MILK, Dr. Peaslee, of New York, recommends that the breasts, after delivery, be tightly strapped by means of adhesive plaster. In five cases he reports perfect results.

PHILADELPHIA
MEDICAL TIMES.

PHILADELPHIA, JUNE 9, 1877.

EDITORIAL.

NOT A CASE OF MALPRACTICE.

A CASE has just been decided in the Supreme Court of Maine which is worthy of brief record. Dr. Eugene F. Sanger, President of the Maine Medical Association, was sued for malpractice by the father of a child upon whom he had operated for club-foot. It appears that for a time the doctor not only attended the child for nothing, but even paid for the Scarpa shoes, but finally, tiring of this, refused to continue the case unless the necessary appliances were furnished. This not being done, the feet reverted to their original form. Seven thousand dollars damages were claimed, because the surgeon, in his treatment of the case, had not followed the practice of Dr. Sayre, and at the operation had allowed the escape of a teaspoonful of blood and had cut the theca of the tendo Achillis. There was quite a long trial, in which it was not proven that the theca of the tendon was cut in this case, but it was proven that no amount of skill or care could prevent with certainty wounding of the theca, and that no more blood was lost at the operation than usual, and that the ultimate bad result was owing to the negligence of the parents. After all this, and after the lawyers had, with great ability, argued the case and earned their fees, the jury brought in a verdict for the defendant. Surely in a case like this the law ought to require the expenses of the defendant to be paid by the plaintiff.

DR. SUTTON, the last survivor of ninety-eight surgeons and assistant surgeons with Nelson at Trafalgar, died recently. He had been over seventy years in the English naval service.

CORRESPONDENCE.

LONDON LETTER.

IN a recent letter I gave some account of the charitable medical institutions of Great Britain, and of the government or imperial poor-law relief organization. In the latter I omitted to say anything of the arrangements made for lunatics and imbeciles. Yet these are now the most elaborate of all the institutions of this country. The growth of these latter is quite of recent origin, and, up to a comparatively recent period, St. Luke's and Bethlem were the only places for receiving insane patients. The latter is the well-known institution in Lambeth, incorporated in the reign of Henry the Eighth, and which has done such an immense deal of good during its long history. The "Tom o' Bedlam" so often referred to by writers indicates the general acquaintance with this institution. St. Luke's was extended in 1757. Since the date of this latter building, lunatic asylums, private and public, have sprung up over the land. The private asylums are under the control of their proprietors, each of whom must be licensed, and in order to procure a license the individual and his residence must be carefully scrutinized as to their respective features. Then there are commissioners in lunacy, who go about and thoroughly supervise the different institutions, listen to the statements and complaints of the inmates, and look into their validity, and, if abuses exist, rectify them. One commissioner, Dr. Crichton Browne, is the Lord Chancellor's visitor, and his duty is to visit the lunatics whose property is controlled by chancery. If the patients are found in squalor, or not treated according to what is fairly to be expected from their social position and means, the owner of the institution is severely reprimanded, and would lose his license if repeated charges were brought against him. Of course, private-asylum keepers vary like any other body of men, and the patients are doubtless more comfortable with some than with others. Even in cases where only a single lunatic is taken into a private house, the commissioners visit yearly, and note the condition of the patient. As to lunatics who are without the means to maintain themselves in a private asylum, they fall under the provisions of the poor-law, and are removed to the public asylums. These public asylums belong either to towns, as borough asylums, or to counties, or unions of counties, as county asylums. Here the patients are kept at the expense of the rate-payers. Before a patient can be admitted into any of these public asylums, the certificate of one medical man, countersigned by a justice of the peace, is necessary. No lunatics are permitted to be kept in the ordinary workhouse, where they cost considerably less than in our public asylums, without special certificates that they may

properly be permitted to remain there; and the commissioners can at any time order these lunatics to be sent to the asylum if there seems any reason to think they would be better there. These workhouse lunatics are under the supervision of the commissioners, so that they are protected from any ill usage, and can prefer any complaint they choose, and be heard. The only lunatics not visited by commissioners are a few harmless imbeciles, whose friends are permitted to take charge of them; but even they are visited quarterly by the poor-law medical officers of the districts. So much for the care taken to see that these unfortunate creatures are not neglected or ill treated.

The great matter of interest connected with the public control of lunatics is the different manner in which insanity is now regarded as compared to times past, and but recently past, too. The horribly cruel treatment of chaining insane people to articles of furniture or to staples in the wall, and feeding them on the coarsest of food, and too often on garbage, and, indeed, keeping them in the most economical manner, is yet remembered by old persons. At present, however, it is only now and again that society is shocked with the details of the treatment of some unfortunate lunatic who has been kept by his relatives in secrecy and in squalor.

The first step forward was to have them placed where they would at least be taken care of, and where they were safe from ill usage and personal violence. In these asylums they were under the control of those accustomed to persons in their condition and acquainted with their wants. If no active attempts towards cure were made, at least kindly thoughtful treatment was secure for them. After a little more time, this plan of merely keeping lunatics out of harm's way, and putting them where they were no longer exposed to the jeers of those around them, often as hard to bear as the bodily pain inflicted upon them, came to be regarded as a social blot, and keen articles were written upon the then existing plan. Perhaps even yet it may be true in one or two instances that asylum-keepers are not anxious to cure, and so lose a lucrative patient; but of the management of our large public asylums this is certainly far from the truth. Amidst the number of really able men who now govern these institutions, the rivalry for pre-eminence, and especially pre-eminence in their percentage of cures, is keen and sustained. Any one who is familiar with the West Riding Asylum Reports issued the last half-dozen years will see what intelligence and perseverance are now brought to bear upon the inmates of that famous Yorkshire asylum. Not only are there no pains spared to do all that medicine can do for them, but those patients who are fit for such duty are permitted to work in the fields, the laundry, and the workshops connected with the asylum. Such exercise and mental activity

are found to be useful curative agents in many cases, while in less hopeful cases they relieve the monotony of the patient's existence. Regular walks under the control of attendants are resorted to for other patients, while even the most helpless and unmanageable are permitted fresh air in the airing court. The chapel is also a remedial agent, and the denial of permission to attend the service on Sunday is a penal agent of no small value. The weekly ball also is a matter of importance, and a patient commencing to be unruly is usually brought to order by the threat of not being permitted to be present at the next ball. Such are the humane measures now resorted to in lieu of the stick, the strait waistcoat, the turning chair, and the water torrent. Those patients who are convalescing are sent to a certain portion of the institution set apart for them, where they can be amidst others recovering, and away from the distressing sight of those who are still unrelieved. The more violent patients are separated from the others whom they disturb, and ceaselessly talkative patients are put among the demented whom even they cannot annoy. Everything is done to take away from the poor lunatic's mind the idea of a jail, and no restraint of any kind is in use there. The padded room is the only coercive measure resorted to. The attendants are carefully supervised, and no unkindliness even of speech is tolerated. Many of the patients after their complete recovery have found there a home, and have taken service in the asylum, rather than return to their friends and be subjected to allusions, how painful they alone can tell, or to a pity equally torturing.

Something may now be said as to the medical measures in use there,—and, of course, elsewhere, but the writer's personal experience is chiefly in relation with the West Riding Asylum. The general health is invariably attended to scrupulously. Fresh air, good food, and clean raiment are supplemented by tonics, hæmatics, and sedatives. Bromide of potassium, chloral, and cannabis indica have been found of great value. For the control of mania the succus conii has been tried, with but doubtful results. Bromide of potassium ʒss, with tinct. of cannabis indica ʒi, is very useful in cases of excitement, especially with progressive softening after a clot, while chloral (ʒss to ʒi) is excellent in the forms of excitement of an epileptic nature. Morphia, in half-grain doses, is found the best agent in mania a potu; while bromide of potassium ʒj and liq. ergotæ ʒiii is the favorite combination in chronic epileptic excitement. The excitement of senile dementia is found to be intractable, and the treatment turns on the peculiarities of each case. In excitement associated with a febrile condition, twenty-minim doses of tincture of digitalis every three hours, night and day, are found to be very efficacious. This treatment

seems especially suited to cases of subacute cerebritis, where great motor impairment and dementia accompany and succeed outbursts of fury. Mustard packing is rarely resorted to, but at times produces excellent results. With these measures are combined a generous diet, and attention to any causes of irritation or excitement, as masturbation, etc.

In melancholia of a hypochondriacal nature, morphia, pushed to one-grain doses, with sulphate of magnesia, has been found to be the most successful practice. In ordinary cases of melancholia, belladonna has produced good results frequently; at times the combination of belladonna with morphia has seemed more satisfactory.

General paralysis is a malady which often taxes the therapeutic skill of the alienist physician. These patients are liable to outbreaks of the most ungovernable character, in which they use excessive violence, and it is with such patients that post-mortem discoveries of several broken ribs are associated. Their violence must be met by some form of restraint, and, as mechanical restraint has been abandoned, of course human control has to be substituted, and in the tremendous struggles which follow the patient is sometimes injured severely, without any malice on the part of the attendant. The wonder really is that more of such cases do not occur. For the control of such outbursts, at one time tartar emetic in scruple doses was given, with the results of immediate prostration, but too often a pustular inflammation of the stomach was the ulterior consequence, of which, not rarely, the patient died. Noting the muscular prostration which experimental research had demonstrated to be the result of a dose of the calabar bean, Dr. Crichton Browne (the medical superintendent) used this agent during the periods of excitement, with excellent results. Not only were these attacks of excitement and furor greatly mollified thereby, but, in a number of cases, the general excitability was lowered, and some improvement even inaugurated. The depressant action of chloral is also of great service in controlling such cases. In some cases it becomes desirable to shave the scalp and rub in croton oil, a measure indicated in the most intense and otherwise intractable forms. In epilepsy, chloral is found very useful, while inhalations of nitrite of amyl ward off the attacks and greatly reduce them in number. Where epilepsy is the result of peripheral excitement, as of the genitals at the climacteric period, at puberty, or occurs with teething, the bromide of potassium is most useful, just as it is in similar affections of the sane. In acute dementia, tonics, warm clothing, exercise, and labor, with extra diet and cod-liver oil, are found of great service. Here, too, it is necessary to watch the habits of the patient, and prevent masturbation. Where it is consecutive to mania, this last measure often leads to

surprising results. Phosphorus has not been found to be of much service in these cases.

This brief sketch will be sufficient to indicate that the spirit of therapeutics is active in this establishment at least, and that the modern treatment of insanity in its various forms involves the most skilful application of remedial agents. The annual reports above mentioned tell that while pathological research, especially histological, is steadily pursued, the etiology of insanity and the effects of remedial agents are carefully studied. In the sixth volume of these Reports, just published, is a paper on hyoscyamine and its utility in the treatment of some diseases of the insane, by Dr. Robert Lawson, a man of whom more will be heard by and by. He has found that hyoscyamine induces a certain amount of intellectual excitement, combined with muscular powerlessness, which renders it admirably adapted to those cases where the furor is as much badness as insanity. In these cases the muscular powerlessness induced by it has an excellent moral effect upon the patient. The sedative effect of henbane upon the genito-urinary organs is well known, and Dr. Lawson has found the extract of especial service in cases of passive retention of urine in general paralytics. One of the greatest nuisances in asylums, as in jails, is the tendency of certain patients to tear up their clothing, bedding, etc. This is quite as much malice as madness, and it is found that a dose of three-quarters of a grain of hyoscyamine in such cases does immediate good, and acts as an effective lesson for some time after. There are other interesting and instructive papers well worthy of perusal in the present volume.

Much of the remedial treatment of the insane consists in the arrangements made for their comfort, and in the attitude and bearing of their attendants. No unnecessary chiding, no unkindness, as well as no neglect, are permitted, under penalty of immediate dismissal. Within his institution the medical superintendent is supreme, and, consequently, his wishes are consulted as well as his orders obeyed. If once the authority of a principal is limited by the interference of the committee, his usefulness is crippled and his prestige gone,—a matter about which committees are hardly sufficiently cautious. As soon as the return of reason permits, the patients are drafted away where their surroundings are still more conducive to complete recovery. When the patient is fit to labor, work is permitted. At stated intervals the friends of the patients are allowed to visit them, and at Easter-time the place is actually crowded by pushing, homely, but kindly strangers making their way to see if their relatives are getting any better; if there is any prospect of their return home even at a distant date; and, failing that, to bring them home-news and accounts of what is happening amidst old friends and acquaintances. The

increasing percentages of recoveries serve to cheer alike the patients and their friends; they are gratifying to the medical officers concerned; and they are acceptable to the rate-payers, who are finding out that it is cheaper to cure lunatics than to keep them under control until removed by natural causes. Consequently, everybody is pleased at the progress made.

There is one uncomfortable feature about these large county and borough asylums, and that is the rate at which they are increasing. Alike in the manufacturing districts of Yorkshire and in the agricultural county of Devon, the increase of asylum-accommodation required is very serious. This matter has attracted much attention, and though doubtless cases of insanity are now much more strictly looked after than in times past, and sent off to asylums, still there can be no doubt that insanity is largely on the increase. That it is not the hopeless matter from a curative point of view that it once was is illustrated by popular comments. When a person is in a towering passion, or furiously drunk, it is common to hear some bystander remark, "A week or two at ——— Asylum would do no harm," mentioning the name of the asylum of that district, or perhaps some more generally notable one elsewhere. Middlesex has just added a third asylum to the old famous institutions at Colney Hatch and Hanwell. This new asylum is on the downs of Banstead, near Epsom race-course, a most healthy locality. In building a Middlesex asylum in Surrey, I believe there was no intention to give any warning to the frequenters of Epsom race-course, but that merely it was the best site procurable within a convenient distance of London. This new building has cost about £400,000, and has accommodation for 2000 inmates. It is intended to draft to this asylum the more promising cases from the other two institutions, the convalescent and the less troublesome patients, leaving the intractable cases where they are. Probably ere long it will be a common saying when a person is becoming more reasonable after an unreasonable period, "He is getting fit for Banstead."

One of the great difficulties of all important institutions where beds and nursing are concerned, is that of the female superintendence. At present St. Mary's Hospital is in convulsions from complications which have arisen in its domestic arrangements. The quarrel, which seems to have commenced in some differences betwixt the resident medical officers and the matron about the nurses, seems to have thrown the whole place into a blaze, from what leaks out of their meetings repeated and prolonged. A large portion of the committee stand steadfastly by the matron, while some of the leading members of the medical staff and of the medical gentlemen on the committee are as earnest on behalf of

the resident medical officers. There has been an extensive washing of much dirty linen, often in small pieces, and even of a fragmentary character, and the laundry-work has not tended to produce the conviction that hospitals are a kind of Paradise for their resident inmates. The ventilation in this scandal is of the most thorough character, and some of the meetings have been very breezy, it is said. So far, however, the matter has not got into the public press, which is rather a misfortune, as thunderstorms clear the air, and the atmosphere of most hospitals and similar institutions is much closer and more sultry than is agreeable.

The following remarks are of a general character, and do not apply in any way specially to the just-mentioned squabble. Committees, as a rule, consist largely of men who are pushing forward socially, and anxious to get on a higher rung of the social ladder than that on which they were originally mounted, and of course they have individually little time to know anything about what really goes on. Consequently, a few members, who have more zeal or more leisure, work the whole thing, and the rest vote with them. In time the impression gets about that these active members discharge their duties thoroughly, and their power and influence are supreme. Often, however, their discharge of their duties is as rotten as that of the bulk of the committee, and they get their information from desultory chats with the secretaries, the head female officials, or perhaps the porters. In fact, they seem to prefer every means of getting information except the straightforward and sound plan of going and seeing the working of the place or places for themselves. The fact that the female element is always or nearly always to be found at home, and without any pressing duties to interfere with a gossip, is a great temptation to members of the committees to drop in upon them in their visit and hear how all goes on from these female sources. It might be uncharitable to insinuate that these elderly personages find feminine utterances more pleasant and easily comprehensible than the more complex and more complete statements that might be made by the younger persons of their own sex, or to hint that the sort of semi-flirtation which thus is permitted has its own attractions; but the facts are that the female officials usually, and as a rule, occupy a very different position from their ostensible one, and the one they ought properly to occupy. It may be said that, generally speaking, these mixed authorities and bisexual governments are the curse of the institutions of England which are supported by voluntary contributions. These women officials in the guerilla warfare of domestic hostilities have the best of it in many ways. They have plenty of spare time, they have lots of opportunities of giving great provocation in small things,

and much tact in seizing upon any acts of retaliation; they are of more mature years, and they have no greater aims or subjects of thought to lift them even temporarily above their uniform littlenesses. If we are to trust to George Eliot's description of the mental processes of Rosamond Vincey in Middlemarch, the female mind is much more engaged with trifles, which they examine with a mental microscope, than with larger things, while this exclusive devotion to small matters unites them for the consideration of greater subjects. There is a plausibility, a capacity to put one side of a subject luminously forward and to leave the other in Stygian darkness, possessed by woman, as compared to man, which doubtless is most effective with gossiping old gentlemen, who undertake what they know they neither can nor will try to perform, if ever they seriously look the subject in the face. The writer has had enough of experience on this subject to know that there should be no woman above a menial rank in any institution which is controlled by a committee, if that committee is made up largely of gray-haired men. If there is a good proportion of younger men the danger is less; but even then it is well to have the ladies of average plainness and limited loquacity. But, as younger men have rarely the leisure or the ambition to get on committees, the only safe plan seems to be that of abolishing the higher female posts, and appointing men superintendents, as at least a lesser evil.

It is very unfortunate that there should be such difficulty in managing women in institutions where, when they do act properly, they are simply invaluable, and that domestic rows should be so constantly brewing and bursting all over the land in our hospitals; for if these higher female posts have to be abolished it increases the already existing difficulties of single women and widows making a livelihood in a reputable way. This is specially unfortunate at a time when several other experiments for employing educated women are cracking. The female clerks in the telegraph department are a failure, for they kept the wires engaged in larking with male clerks, to the great hindrance of business. The London and North-Western Railway Company have given up their female clerks at the windows: they could not subordinate their flirtation-instincts to the requirements of the passengers, and so guards could not get their trains away with punctuality. In fact, as women are educated at present they do not seem capable of properly comprehending the importance of business and the necessity of subordinating all other matters to it,—that is, during business hours; and until they do, business must simply do without them. That they should also be practical failures in the domestic management of institutions is a matter for still deeper regret. On talking the matter over with a cynical and

confirmed bachelor, he suggested that there was still another plan of enabling committees to work with superior female officials which might be worth trying. He founds the idea on a remark often made by the cleverest woman he knows, viz.: that nobody but a woman can understand a woman. Assuming this to be true, as it probably is, it might be well to have a lady or two on each committee, so as to secure a true and just equilibrium once more, and enable institutions under double and bisexual executive to work smoothly. The lady on the committee would and could easily counteract and explode all the secret ways and doings which are so undiscoverable and dark to the male vision.

The smallpox is declining, and the other evening the medical superintendent of a smallpox hospital—it may be as well not to particularize which—was heard bewailing the fact as interfering with his observations as to the excellence of the cold bath in lowering the pyrexia in this disease.

PROCEEDINGS OF SOCIETIES.

PATHOLOGICAL SOCIETY OF PHILADELPHIA.

THURSDAY EVENING, FEBRUARY 22, 1877.

The PRESIDENT, DR. H. LENOX HODGE, in the chair.

An arm amputated after diffuse cellulitis. By DR. W. W. KEEN.

M. C., æt. 53, Irishman, miner, blanched by thirty years of almost absolutely sunless life. In 1867 was struck on the left elbow by a piece of coal from a blast. This wound never healed. Ankylosis of the elbow resulted, and over the olecranon the bone was exposed on a level with the skin over a space about one-half inch in diameter. For six months there was considerable inflammation of the tissues of the arm and forearm, with abscesses. In December, 1875, the same arm was squeezed between a coal-wagon and a heavy timber. Diffuse inflammation soon followed, from the elbow down, with enormous swelling and abscesses everywhere. In this condition he entered St. Mary's Hospital, October 18, 1876. No dead bone, however, was detected on probing. Slight power of pronation existed, but no flexion. A short effort was made to save the limb, but, finding it of no avail, amputation, by two flaps, was done October 28, 1876, at the middle of the humerus. Esmarch's apparatus was used successfully, only the bandage and no tubing being used, after the plan suggested by myself. Three ligatures were applied. On the seventeenth and twentieth days two ligatures came away. The one on the brachial artery

resisted all proper force, and after forty days I attached to it a bag containing one ounce of shot, which brought it away in two days. He was discharged, well, December 9, 1876. On examining the elbow, entire bony ankylosis existed between the humerus and ulna, but the radio-humeral articulation was entirely healthy, apparently, from the slight pronation which was preserved. The exposed olecranon was not diseased beyond the exposure.

Post-sternal abscess. By Dr. W. W. KEEN.

J. G., æt. 35, baker, was admitted to St. Mary's Hospital July 11, 1876, under the care of Dr. S. H. Griffith, the attending physician. He had fever, anorexia, and sleeplessness, which persisted apparently without assignable cause. He complained of no pain in the chest. In about two weeks a swelling appeared at the right edge of the sternum at the second rib, not painful, but with only a sense of fulness. It was hard and small. After poulticing for ten days, fluctuation was evident, and it was opened. In the pus a wave was seen synchronous with the heart-impulse, showing some mediastinal connection, and the diagnosis of post-sternal abscess was made. His general condition at once improved in every respect, steadily though slowly, under good diet, tonics, and mild stimulation. Early in September he was walking out daily. The abscess had at first discharged freely, and had nearly filled up by granulations. About September 20 he took a long walk down town to get some clothes, and returned utterly exhausted. He went to bed, the fever returned, the granulations melted away, night-sweats set in, and his general condition was very bad. He came under my care October 7. I found his general condition as stated, temperature 102° to 105° morning and evening, pulse 120 to 140. At the junction of the manubrium and gladiolus, which were entirely separated about an inch from each other, was an oval opening two inches wide by one and a half inches perpendicularly and one and a half inches deep. At the bottom, which was a smooth membrane, the aortic pulsations could be both seen and felt. Exploration carefully made by the finger was not painful. The finger passed behind the sternum, and showed a cavity extending about an inch laterally beyond the opening, upwards to the top of the sternum and downwards to the ensiform cartilage. The tissues in front of the sternum were also detached from the bones. Both pieces of the sternum were carious, and small pieces of bone were constantly coming away. Both second ribs were detached, and could be seen and felt, the right one rather the better since the opening was slightly more to the right than to the left.

He was very feeble, and the prognosis was very bad. In spite of careful regulation of his diet, liberal stimulation, and the adminis-

tration of tonics in full doses, he gradually failed, and died October 18. The local treatment was directed solely with a view to keep the parts clean and stimulate the granulations, but, except in the matter of cleanliness, it failed entirely to be of benefit.

The *post-mortem* examination revealed nothing worthy of note beyond the abscess described. The heart and pericardium were not diseased. The only assignable cause for the abscess was that in his occupation he constantly carried barrels of flour and ashes up and down, the edges of which he generally rested on his chest; yet he was never conscious of any injury received by so doing.

Carcinoma of stomach, causing constriction four inches above the pylorus, with corresponding constriction of transverse colon; scattered secondary growths in liver, omentum, and mesentery. By Dr. J. C. WILSON.

The specimens exhibited were taken from the body of P. F., a blacksmith, born in Ireland, who died at the age of sixty-two, in the Philadelphia Hospital, February 10, 1877. He was admitted to the ward five days before his death, but had previously, at long intervals, come under my observation at the out-patients' department of the Jefferson College. The following notes are condensed from the ward-record of the case:

Until seven years ago was a stout, healthy, hard-working man. At that date he began to be dyspeptic, and soon became so bad that he failed greatly in strength, and was obliged to give up work.

At first the symptoms were those of difficult digestion, with a sense of distress some time after taking food, occasionally vomiting, and constipation. Pain in the epigastric region soon began to trouble him. These symptoms grew gradually worse; he lost flesh, his skin became sallow, but remained free from actual jaundice during his attendance at the College as an out-patient, which continued until about a year before death. Liver-dulness was about normal, and no epigastric tumor could be felt. During the past year he was several times admitted to the Philadelphia Hospital, making short stays in the wards.

At the final admission he was very ill. Skin and conjunctivæ were of a deep orange-yellow hue. Emaciation was extreme. His belly was considerably distended; it was symmetrical in outline, and on examination this swelling was found to be chiefly due to fluid in the peritoneal cavity. There was also a good deal of tympany. On the most careful palpation in various attitudes, no distinct tumor could be felt, nothing more definite than an obscure sense of resistance to the right of the median line in the epigastrium. The liver-dulness in the mammary line began at the fifth rib, and reached a distance of three and a half inches. No tenderness in the hepatic region. The superficial veins of the abdomen were slightly enlarged, and filled from below.

There was faint pitting of the tissues around the ankles on pressure. Pulse, 100. No cardiac disease. Chest clear on percussion; no evidence of any intra-thoracic malady.

The tongue was coated with a pasty fur. There was no desire for food; liquid diet was vomited a short time after it was taken; no solid food was given whilst he was under observation. On one occasion a small quantity of blood was vomited. His bowels were once moved whilst he was in the ward; the character of the stool was not observed. He stated that constipation had been stubborn for a long time, and that the stools were light in color.

Pain was constant, often intense; it was referred to the gastric region, where also there was great tenderness on pressure.

Diagnosis.—Malignant disease of the stomach, with implication of the liver.

Post-mortem examination.—Brain not examined.

Nothing bearing on the case was discovered in the thoracic viscera, which, save a few points of aortic atheroma, were normal.

The abdomen contained several pints of fluid. Everything was stained deep-yellow.

The stomach was encircled by a mass of new tissue which was extremely dense and hard, bloodless, creaking under the knife, presenting in fact all the naked-eye appearances of scirrhus. This tumor implicated the wall of the viscus in the form of a ring, the thinnest part being on the posterior wall, the greatest mass in front and below where it crossed over to involve the transverse colon in its grasp, causing a similar but more marked stricture of that portion of the gut lying opposite the constriction of the stomach. This narrowing of the stomach was four inches above the pylorus, and its lumen was about equal to that of the pyloric outlet. In the neighborhood of the mass the gastric mucous membrane was softened but not ulcerated. The bulk of the tumor at this point was that of a small orange.

The transverse colon above the region of the constriction was greatly distended with flatus, and contained a small amount of fecal matter.

On the under surface of the liver, at the porta, was a smaller cancerous mass of the same appearance, and several similar tumors of small size were found in the interior of the organ. The liver weighed three pounds six ounces. Several nodules the size of chestnuts were in the great omentum and at various points in the mesentery, reaching down towards the small intestine, but not constricting it. No new growth of the cancerous kind was found in any other organ.

Dr. E. O. SHAKESPEARE, to whom these morbid growths were referred for a microscopic examination, said that sections were made from the hard, fibrous-like mass which bound the transverse colon to the greater cur-

vature of the stomach, from a portion of the duodenum involved in a similar growth, from some small nodules found in the mesentery near the latter location, from the dense fibrous-like growth surrounding and obstructing the portal and biliary vessels and the hepatic artery at their entrance into the liver, and from some of the small white and consistent nodules which studded the parenchyma of the liver.

The sections were all stained with carmine, and examined in glycerin with a Harnack No. 8 dry.

Those cut from the morbid point of the duodenum exhibited the usual structure of scirrhus cancer. The growth was confined mainly to the submucous tissue and to the muscular coat; it extended, however, for some distance into the mesentery at its point of attachment to the lesser curve of the intestine. Numbers of epithelioid cells with granular contents and large round nuclei, and often large nucleoli, were to be observed filling oval or somewhat lozenge-shaped alveoli, which were formed by the interlacing and frequent union of thick bands of fibrous trabeculae. Within these trabeculae, mainly over the position of the nodal points, small masses of flattened and proliferating cells were to be easily seen. The nuclei of the trabeculae were all in a state of irritation. Within a few of the larger trabeculae small blood-vessels could be seen. The cells of the mucous follicles adjacent to this morbid growth were in a state of irritation, but the glands had not encroached upon the submucous tissue, nor had they ulcerated. The sections from all the masses other than those present in the parenchyma of the liver offered similar pictures. It may, however, be stated that the cancerous growths around the vessels entering the liver appeared to start from the adventitious coat of those vessels, and to extend into the substance of this organ only along their course. The adventitious coat of the hepatic artery seemed to be the point of greatest activity. The muscular wall did not appear to be particularly touched; but the lumen of the vessel was somewhat narrowed by a growth of the endothelium. Indeed, this irritation of the endothelium was not limited to that portion of the artery which corresponded to the surrounding scirrhus mass at the entrance of the vessels, but it could be distinctly observed in sections of the liver itself, extending even to the finest ramifications of the artery.

Now we come upon the nodules which studded the parenchyma of the organ. The smallest of these were found to occupy positions with respect to the lobules corresponding to the position of the fine branches of the hepatic artery and portal vein and bile-ducts. It was still the tissue around the arterioles of the hepatic artery, and around the vessels and nerves running with it, from which the morbid growth in the parenchyma sprang. When

acini were destroyed the destruction began in portions bounded by the arterioles, and progressed radiating from that centre. Now, with respect to the character of these nodules. Where the arterioles were not utterly destroyed, a narrow cylinder of the tissue surrounding the vessel presented the alveolar structure and cell-heaps of cancer, and the proportion of the size of the fibrous trabeculae to that of the enclosed cell-masses showed some predominance of that of the former over the latter. Hence I would decide that this wall area partakes more of the scirrhus. But outside of this small zone of scirrhus, which was not to be seen at all if the arteriole had undergone destruction, the alveoli quickly became round. The cells filling them were irregular in shape from pressure, were often polynucleated, and caudate. The fibrous trabeculae limiting the alveoli were thin and nucleated, and bore only a very small proportion to the diameter of the alveoli. This zone should probably be designated as medullary carcinoma. Beyond it the cells and their relative arrangement gradually passed into the normal condition of the healthy glandular structure. Speaking in a general way, then, of the nodules which studded the liver, they were determined to possess the character of medullary cancer.

It should be stated that a portion of the hard mass in the walls of the stomach, including the mucous membrane, was also hardened for section, but could not afterwards be found.

Dr. HODGE said the time of the vomiting after eating was interesting in connection with the seat of the tumor. He had now a case under observation in which he could easily pass a bougie as far as the cardiac extremity of the stomach, but it does not enter the stomach. The patient vomits within a few minutes after taking food, and it was a question whether the obstruction is at the pylorus, the cardia, or between these points.

Dr. C. B. NANCREDE said it was an interesting fact in this specimen that where connective tissue is normally present in large amount, as in the stomach and mesentery, the secondary morbid growths are scirrhous; whereas in the liver, where the connective tissue is very sparse, we have encephaloid. Where the breast is removed for primary cancer, the secondary growth is usually much softer. This, Dr. Nancrede thought, is explained by the enormous quantity of connective tissue in the gland primarily, which is removed with it, leaving nothing but the subcutaneous connective tissue. There would therefore seem to be an anatomical reason for the secondary growths being softer than the primary. Where a small amount of connective tissue is present, the tendency is to medullary formations; where, on the other hand, this element is large, we have the scirrhous growths, or, at least, the harder forms of encephaloid.

Interstitial nephritis, in which there were marked retinal changes. By Dr. J. H. HUTCHINSON.

See Original Communication in the current number of the *Medical Times*.

Dr. JAMES TYSON said it was well known that retinal changes must frequently attend the cirrhotic form of chronic Bright's disease, but he had now under his care a case of chronic Bright's disease in the wards of the Philadelphia Hospital in which there are marked retinal changes, where there has been undoubtedly chronic catarrhal nephritis, although it is by no means impossible that there may now be secondary contraction of the organ, as the case is one of long duration.

Dr. OSGOOD said that Traube mentions having seen a case of the so-called amyloid degeneration of the kidneys complicated by retinitis, and quotes cases published by Wagner and others. In his case, Traube found hypertrophy of the left ventricle, and he not only asserts that there is no well-authenticated case on record in which retinitis co-attending amyloid or other disease of the kidney was not also accompanied by hypertrophy of the left ventricle, but insists that retinitis is essentially dependent upon the cardiac hypertrophy. Rosenstein, referring to Wagner's cases, remarks that in one of them there was no hypertrophy of the left ventricle. But Traube believes the latter condition was overlooked because slight in development, and says that Schweigger accounts for the exception by expressing the opinion that retinitis did not exist in all of Wagner's cases, for at the time of Wagner's first publication the later ophthalmoscopic and anatomical discoveries in retinitis were not known. Traube further says that Von Graefe has also confirmed the existence of hypertrophy of the left ventricle in all cases of retinitis attending nephritis which came under his notice, and that Von Graefe also saw cases of apoplexy of the retina (with formation of layers of fat) in which there was no affection of the kidneys, but always hypertrophy of the left ventricle.

Dr. HUTCHINSON did not wish to be understood as stating that these changes do not occur in other forms of Bright's disease, but as they are generally associated with the cirrhotic form, he thought that the use of the ophthalmoscope would often render the diagnosis much easier than it would otherwise be, as in the case reported by him this evening, where it had been made before any history could be obtained. He was aware, as had indeed been mentioned in his report, that the occurrence of the retinal changes was asserted by some observers to be a consequence of hypertrophy of the heart,—which is, as is well known, a frequent accompaniment of Bright's disease,—rather than of the Bright's disease itself; but it must not be forgotten that it is in the cirrhotic form that hypertrophy of the heart oftenest occurs.

Cases in which the retinal changes are marked are, however, Dr. H. went on to say, not often seen in the wards of a general hospital; they are more often met with at the clinics for diseases of the eye, the impairment of vision caused by them being generally the most prominent symptom. Indeed, such is the insidious manner of approach of the cirrhotic form of Bright's disease that it may be the only symptom which has attracted the patient's notice, as in a case which recently came under Dr. H.'s observation. The patient, an apparently healthy man of middle age, feeling perfectly well, scouted the idea of his being the subject of kidney-disease when it was suggested to him as possible. His urine, nevertheless, was found, upon examination, to contain albumen and casts, and he has since died in uræmic convulsions. On the other hand, although Dr. H. has examined ophthalmoscopically the eyes of every patient with albuminuria in his wards for several years past, he has found the retinal changes in only a few instances.

Dr. J. T. ESKRIDGE said that at the eye and ear clinic of the Philadelphia Dispensary a young lady had recently presented herself with marked retinitis albuminurica, easily recognized by all the assistants. On inquiry she said she had been treated for Bright's disease for three years.

Dr. TYSON remarked that occasionally we had an opposite result. A lad about 14 years old complained of his eyes, and consulted an eminent ophthalmologist of this city. The latter was struck with the condition of the eye-ground as that of retinitis albuminurica, and sent him to Dr. T. for an examination of his urine. The urine was examined, with negative results. Some weeks later a second examination was made, with a similar result. The boy continues well, and nearly two years have elapsed.

Heart, liver, and kidneys from a case of cardiac valvular disease. By Dr. F. P. HENRY.

L. W., æt. 14, printer, was admitted to the Episcopal Hospital on July 10, 1876, with acute articular rheumatism. He had had two previous attacks, involving nearly all the joints. When admitted, both knees and ankles were swollen, very painful, and red. On July 11 he was put upon the use of salicylic acid, gr. v every hour, and the joints were painted with tinct. iodine. On the evening of the same day he was almost free from pain. On the 12th he took thirty grains of the acid, when it was stopped, as the "cure was complete; swelling, pain, and stiffness having all vanished." On July 13 he was allowed to sit up, and on the 15th, it is stated, "he still continues in excellent condition." On the evening of the 15th he had a relapse, the knees and ankles being again attacked; this followed imprudent exposure to the air on one of the porches, where he had gone without permission. The treatment by sali-

cyclic acid was resumed, and the pain was almost immediately relieved. On the 17th he complained of severe pain over the cardiac region, with dyspnoea. A friction-sound was heard. Subsequently an endocardial murmur was detected; valve affected not stated. From this time on, the symptoms were those of gradually increasing disorder of the circulation.

The boy was in bed when I took charge of him on June 1, but was soon able to get up, and did so daily until about two weeks ago. He then took to bed again with symptoms of orthopnoea, sick stomach, and pain in right side. When I first saw him he was cyanosed, and his eyelids œdematous. The transverse area of cardiac dulness was increased, and the impulse was seen and felt over a wider extent than normal, being quite perceptible to both sight and touch in the epigastric region. The auscultatory signs were by no means so distinct as the very decided symptoms led one to expect. There were murmurs with both sounds, heard most distinctly at the apex; in the sitting posture the murmur corresponding in time with the second sound was only heard; standing developed the systolic murmur, which somewhat resembled a friction-sound. There was marked jugular, venous pulse. The boy died suddenly on Saturday morning, at 1 A.M.

Autopsy.—The heart weighed one pound nine ounces, and the pericardial layers were adherent. Both ventricular cavities were dilated, but especially the left; this condition decidedly predominating over hypertrophy. The aortic valves are thickened; their edges uneven and eroded; the portion that in healthy valves is found internal to the line of closure is gone. The left auriculo-ventricular orifice is dilated, and the mitral valves along the lines of closure are thickened and covered with minute "vegetations." The tricuspid present similar appearances in a minor degree.

The lungs were but slightly congested, and presented here and there a few stripes of pigment, but were far removed from the condition known as brown induration.

The liver weighed two pounds and three ounces, and presented the nutmeg appearance in a marked degree on section.

The kidneys weighed five ounces each. The relative amounts of cortical and medullary substance are about normal. These organs are paler and denser than usual. They are evidently fatty, and might, from the gross appearance, be supposed to be granular, but the microscope shows no development of intertubular connective tissue. I omitted to mention that the urine contained albumen, but was not examined for casts. The capsules of the kidney were in parts adherent, portions of the parenchyma coming away with them.

I believe that in this case the aortic valvular disease was primary. This led to hypertrophy,

followed by dilatation, which gradually increased, involving the left auriculo-ventricular orifice to such an extent as to cause mitral insufficiency. But for the dilated auricle, an aortic systolic murmur would doubtless have been detected; the sounds heard at the apex being those of aortic and mitral insufficiency.

The presence of a pathological condition of the liver due to great and long-continued venous congestion, in connection with mitral insufficiency, is of considerable interest; and especially when it is considered that the lungs, whose vascular system is in direct relation with the diseased valve, were scarcely congested. I submit the following explanation of the group of lesions, consisting of mitral disease and nutmeg liver, with but slight congestion of the lungs.

A certain amount of tricuspid insufficiency is considered normal by most physiologists since the time of Hunter, and is known as the safety-valve action of the heart. During sudden exertion more blood is returned to the right heart, through muscular pressure upon the veins, than can be propelled through the pulmonary circuit, and consequently at each ventricular contraction there is a regurgitation of blood, distending the veins and manifesting itself through the venous pulse. The lungs, as it were, refuse to receive more blood than can be aerated. The same condition may obtain in inflammatory affections of the lungs and in mitral insufficiency.

In the latter affection the lungs constantly approach a condition which normally obtains only during muscular exertion, and the safety-valve action is in continual operation. One result of this is hepatic congestion, which is conservative, a gland being less liable to be affected injuriously by congestion than a purely vital organ such as the lung, brain, or heart. It relieves itself through its secretion, or, as in the case of the liver, through its mingled secretion and excretion. It is congested physiologically at certain intervals, notably soon after eating, and therefore a pathological congestion may be invoked to explain the anorexia which is so frequent a symptom of cardiac disease. In healthy individuals, and especially in young persons, after sudden or even moderate exertion, such as rapid walking, a pain in the right side is frequently complained of. I consider this as due to hepatic congestion from the normal tricuspid insufficiency. It is more commonly observed soon after eating, when the liver is already congested. In the case of the boy L. W., there were complaints of pain over the right lobe of the liver; the same as would be due to muscular exertion. Indeed, the condition of a patient with marked cardiac valvular disease, even when at rest, so closely resembles that of a healthy individual making violent voluntary exertion, that it would be interesting to determine whether the same tissue-changes, as indicated especially by the

urine, fæces, expired air, and perspiration, do not occur in both instances.

Enormous cystic kidneys: stricture of the urethra. By Dr. J. H. BRINTON.

These two kidneys were taken from the body of a man aged 45. His history was as follows. He first contracted a gonorrhœa ten years ago, which was cured in about a month and a half. He again contracted a gonorrhœa a year and a half since, and again about July, 1876. In the last three months he had experienced great difficulty in passing his water, the stream gradually diminishing until it passed only in drops, and the effort of urination was accompanied always by severe straining and by much pain. In December, 1876, he was admitted into the Philadelphia Hospital, with symptoms amounting almost to retention. On examination two urethral strictures were detected, one situated about two and a half inches from the meatus, and the posterior one, which was very tight and firm, about five and a half inches from the orifice.

The anterior stricture was dilated without difficulty; the posterior one proved to be obstinate, and, although it could be passed, resisted to a marked degree instrumentation with catheters and sounds of a greater calibre than Nos. 3 and 4 of the English scales. By gentle manipulation it was, however, dilated so that Nos. 8 and 10 could be passed, but the passage of instruments was at times attended by decided evidences of urethral irritation. The urine was at different periods in his treatment examined, but no albumen or other abnormal constituents could be detected. During the early part of February vague symptoms of abdominal irritation occurred, accompanied by a persistent hiccough which defied all treatment. The man gradually became worse, œdema of the lungs supervened, and he died on the 18th of February.

On *post-mortem* examination the heart was found to be healthy, the lungs were both œdematous, and both kidneys were enormous and equally enlarged, and filled with multilocular cysts containing a limpid fluid. Each kidney, when placed in a jar, displaced about one hundred and fifty-six ounces of water. The ureters were normal, the walls of the bladder slightly thickened, and in the urethra the posterior stricture above described was found to be firm and impervious to the passage of a No. 9 sound; the anterior stricture was dilated; the prostate gland was normal.

The specimen was referred to the Committee on Morbid Growths.

Report of the Committee on Morbid Growths.

"The kidneys presented by Dr. Brinton and referred to the Committee on Morbid Growths show, microscopically, numerous large and small cysts containing a yellow semi-fluid substance. A thin section, by microscopic examination, exhibits the secreting structure of the kidney, which has not been

destroyed by the formation of the cysts, to be in an advanced stage of interstitial nephritis, the blood-vessels, uriniferous tubes, and Malpighian bodies being surrounded by a dense fibrillated tissue. The uriniferous tubules are in places completely obliterated; their lumen cannot be recognized, and the lining cells are in a state of fatty degeneration. A microscopic examination of the cysts shows their walls to consist of fibrous tissue, lined upon the inside by a flat epithelium; their contents consisted of large epithelial-like cells, irregular in shape, some measuring as much as $\frac{1}{200}$ of an inch, numerous pus-corpuscles, fat-globules, and granular débris. From which your committee consider the kidneys to be in a state of cystic degeneration, with secondary chronic interstitial nephritis.

" March 8, 1877."

REVIEWS AND BOOK NOTICES.

TABLES OF MATERIA MEDICA. By T. LAUDER BRUNTON, M.D. London: Smith, Elder & Co.

This book of about two hundred pages is simply a series of tables in which are given the drug, source, mode of preparation, properties, reactions, impurities, source of impurities, tests, action, use, dose, in the briefest possible manner. The making of the book must have involved a great deal of weary mechanical labor, and as "a companion to the *Materia Medica Museum*" it will save the student much toil. For solidity of work it well maintains the enviable reputation of its author. The fact that the preparations given are only those official in the English Pharmacopœia renders a revision of the tables imperative for the American student.

SCHEDLER'S MAP OF TURKEY AND GREECE.

This is a very good map of the seat of war, on rather remarkably good paper, and of sufficient size to allow marking of all the important points of the territories. We would advise those of our readers who peruse the daily papers to enclose twenty-five cents to the publisher, E. Steiger, 24 Frankfort Street, New York, asking for No. 2, cheap edition.

GLEANINGS FROM EXCHANGES.

TREATMENT OF HYDATID TUMORS OF THE LIVER (*The Lancet*, April 7, 1877).—Dr. Wadham, after reporting a case of double hydatid tumor of the liver, which was rapidly destroyed by paracentesis of each cyst and withdrawal of its fluid contents, proceeds to remark that the principal means suggested for the cure of these cysts were:—1. Simple

acupuncture. 2. The electrolytic treatment (which consists in puncturing the cyst with two fine needles, attached, by means of metallic wires, to the negative pole of a galvanic battery, and applying over the integument in their neighborhood a moistened sponge connected with the positive pole). 3. Paracentesis, and withdrawal of the fluid contents of the cyst by some form of aspirator. 4. Puncture, with a view of allowing the cyst to be subsequently destroyed by suppuration. Of these methods he considered the last, in whatever way performed, needlessly painful, always tedious, and open to many sources of danger. Acupuncture and electrolysis, even if they could be relied upon, had also both of them the disadvantage of leaving for a long time in suspense the success or failure of the operation; the gradual dispersion of the tumor when so treated often occupying many months. If the cures following these forms of operation were, as he believed, simply due to the gradual escape of the fluid contents of the cysts into the cavity of the peritoneum, he considered that in paracentesis and withdrawal of the fluid by some form of aspirator we had a safer and a far more expeditious mode of treatment. This latter was, therefore, the operation for which he had a decided preference. The instrument which he had used, instead of any form of aspirator, was the same that he had frequently employed in cases of paracentesis of the chest. It was simply a double-action glass syringe, which admitted of the fluid being gradually withdrawn from the cyst without the admission into it of any air. It had, in his opinion, the advantage of allowing the operator to regulate, in a manner not possible with an aspirator, the amount of force employed in withdrawing the fluid, and enabling him to judge, by the resistance experienced, when the operation should cease.

LARYNGOTOMY IN CHLOROFORM ASPHYXIA (*The British Medical Journal*, February 3, 1877).—Mr. J. T. Clover reports a case in which during an operation for the removal of an epithelioma of the tongue, the patient being under the influence of chloroform, paralysis of the glottis and consequent asphyxia suddenly occurred. Drawing the tongue forward and making movements of artificial respiration produced no effect. The radial pulse could not be felt; and though at first the air passed through the larynx audibly, the sound soon became a short hiccup and then ceased. Laryngotomy was then immediately performed, artificial respiration continued, the operation completed, and the result was the entire recovery of the patient. Mr. Clover concludes his account of the case with the following remarks:

"Although it is certain that laryngotomy in this case was an important factor in the patient's recovery, and most probably an essential one, I should regret if this record were to

lead any one to open the larynx without *sufficient* necessity. I have never used the canula before, although it has been my companion at some thousands of anæsthetic cases; and I should never use it so long as air could be made to pass by artificial respiration through the glottis, or so long as the pulse could be felt. Whilst the circulation goes on, the patient will almost certainly gasp, and, in gasping, I believe the larynx opens sufficiently to make laryngotomy unnecessary; but when, under artificial respiratory movements of the thoracic walls, *glottidean respiration ceases and no pulse can be felt*, the prompt admission of air through an opening in the larynx, coupled, of course, with perseverance in the Silvester method, appears to me an imperative duty, especially as the operation is so exceedingly simple, free from risk, and cannot do any direct harm."

PAIN IN THE CHEST OF OBSCURE ORIGIN (*The Lancet*, March 31, 1877).—Dr. J. Sherwood Stocker calls attention to a series of cases, chiefly characterized by pain, either around one or both sides of the chest, or around the chest and down the arm, without any apparent cause.

After carefully eliminating all sources of error, as the possibility of pleurisy, herpes, aneurism, dyspepsia, and other disorders of the digestive organs likely to cause error in our diagnosis, it will generally be found that on one side of the upper dorsal vertebræ, near the exit of the spinal nerves, there is a spot exquisitely sensitive to pressure. In most cases, a simple blister applied over the painful part, with tonics given internally, will suffice to cure the invalid. In other cases, an opiate plaster, with a tonic, will be found to be the more appropriate remedy. In some of these cases a history of injury to the spine from a fall or blow of some kind will be traceable, though in some cases the cause has been so slight as to have escaped the patient's memory and the fact has had to be brought to his recollection by a friend. In other cases no history of such an accident can be obtained. These cases have nothing whatever to do with any functional disturbance of the uterus in females.

Another and somewhat similar class of cases is characterized by pain around the chest or down the arm, and functional disturbance of the heart's action. In these cases some tender spot may be detected at or near the same region of the spine previously mentioned; and also there may be a cicatrix at one extremity of the fingers from a former injury, such as a gunshot wound having implicated the cutaneous nerve. This was the case in an officer who consulted Dr. Stocker. Tonics and a sedative liniment cured him. The consideration of his case tends to confirm the opinion of the American surgeons from observations made during the late war,—that injuries causing irritation to the brachial plexus of nerves induced much more severe

constitutional disturbance than the same amount of injury to the lower extremities.

NOTES AND QUERIES.

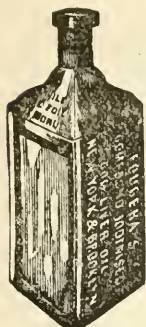
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OFFICIAL LIST

OF CHANGES OF STATIONS AND DUTIES OF OFFICERS OF THE MEDICAL DEPARTMENT U.S. ARMY FROM MAY 20, 1877, TO JUNE 2, 1877, INCLUSIVE.

- WOODHULL, A. A., SURGEON.—Assigned to duty at Alcatraz Island, California. S. O. 50, Division Pacific, and Department of California, May 14, 1877.
- GREENLEAF, C. R., SURGEON.—Assigned to duty as Post Surgeon at Thomas Barracks, Huntsville, Alabama. S. O. 85, Department of the Gulf, May 25, 1877.
- BROOKE, J., ASSISTANT-SURGEON.—Assignment to duty at Greenville, S.C., revoked. S. O. 94, Department of the South, May 18, 1877; and leave of absence extended thirty days. S. O. 98, Department of the South, May 23, 1877.
- GARDNER, W. H., ASSISTANT-SURGEON.—Assignment to duty at Columbia, S.C., revoked. S. O. 94, c. s., Department of the South.
- BENTLEY, E., ASSISTANT-SURGEON.—Assigned to duty at Little Rock Barracks, Arkansas. S. O. 76, Department of the Gulf, May 14, 1877.
- HEIZMANN, C. L., ASSISTANT-SURGEON.—Assigned to duty at Fort Niagara, N.Y. S. O. 109, Division of the Atlantic, May 19, 1877.
- MOFFATT, P., ASSISTANT-SURGEON.—Assigned to temporary duty at Fort Hamilton, N.Y. S. O. 112, Division of the Atlantic, May 23, 1877.
- WOODRUFF, E., ASSISTANT-SURGEON.—Assigned to duty at Fort Davis, Texas. S. O. 88, Department of Texas, May 15, 1877.
- KING, WM. H., ASSISTANT-SURGEON.—Assigned to duty at Fort Sully, D. T. S. O. 65, Department of Dakota, May 26, 1877.
- COWDREY, S. G., ASSISTANT-SURGEON.—Assigned to duty at Mt. Vernon Barracks, Alabama. S. O. 80, c. s., Department of the Gulf.
- DICKSON, J. M., ASSISTANT-SURGEON.—Assigned to duty as Post-Surgeon at Jackson Barracks, Louisiana. S. O. 82, Department of the Gulf, May 22, 1877.
- PRICE, C. E., ASSISTANT-SURGEON.—Assigned to duty at Camp Gaston, California. S. O. 50, c. s., Division Pacific, and Department of California.
- BARNETT, R., ASSISTANT-SURGEON.—Assigned to duty with battalion Thirteenth Infantry, under command of Captain Clift, ordered to Lake Charles, Calcasieu Parish, Louisiana. S. O. 80, c. s., Department of the Gulf.
- TORNEY, G. H., ASSISTANT-SURGEON.—Assigned to temporary duty at the Custom-House, New Orleans, Louisiana. S. O. 85, c. s., Department of the Gulf.
- CRAMPTON, L. W., ASSISTANT-SURGEON.—To accompany battalion of Third Infantry to Holly Springs, Mississippi, and, upon arrival, assigned to duty as Post-Surgeon at that post. S. O. 87, c. s., Department of the Gulf.
- TAYLOR, M. E., ASSISTANT-SURGEON.—To accompany battalion Thirteenth Infantry to Baton Rouge Barracks, Louisiana, and, on arrival, resume his duties as Post-Surgeon at that post. S. O. 82, c. s., Department of the Gulf.
- SHUFELDT, R. W., ASSISTANT-SURGEON.—To proceed at once to Fort D. A. Russell, Wyoming Territory, for duty with companies of Fifth Cavalry, detailed for field service near Cantonment Reno, Wyoming Territory. S. O. 65, Department of the Platte, May 22, 1877.



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SESSION OF 1876-77.

THE READING AND RECITATION TERM will commence October 4th, 1876, and close at the commencement of the Regular Term.

THE REGULAR TERM will open March 1st, 1877, and close the last week in June following.

FACULTY OF THE COLLEGE.

DANIEL AYRES, M.D., LL.D., Emeritus Professor of Surgical Pathology and Clinical Surgery.

SAMUEL G. ARMOR, M.D., LL.D., Professor of the Principles and Practice of Medicine and Clinical Medicine, and Dean of the Faculty.

CORYDON L. FORD, M.D., Professor of Anatomy.

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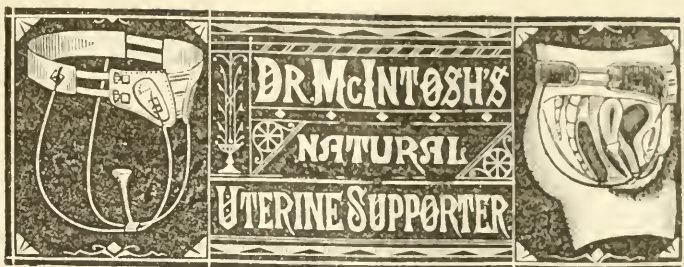
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